Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
HARRIS METHODIST FORTH WORTH
P.O. BOX 916063
FT WORTH, TX 76013

Respondent Name
AMERICAN HOME ASSURANCE CO

MFDR Tracking Number
M4-05-9884-01

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
19

MFDR Date Received
JUNE 24, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from Table Of Disputed Services: "The total billed charges on this claim was 87656.81 I am requesting that his claim be processed at 75% of the billed charges at the stop loss rate implants req cost plus 10%."

Amount in Dispute: $28,924.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated July 13, 2005: "This is a medical fee dispute arising from an inpatient hospital surgical admission, dates of service 02/24/2005 to 02/27/2005. Requestor billed a total of $87656.84. The Requestor asserts it is entitled to reimbursement in the amount of $65743.00, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges … To qualify for stop loss, the services provided by the hospital must be unusually costly to the hospital as opposed to unusually priced to carrier. The services provided by the hospital (not by a physician attending a patient while in the hospital) must be unusually extensive. Exceptional cases will be entitled to reimbursement under the stop loss exception. There is no evidence submitted by the hospital demonstrating that the services provided by the hospital were unusually extensive. There is no evidence of "complications, infections, or multiple surgeries" requiring additional services by the hospital."

Response Submitted by: Flahive, Ogden & Latson

Respondent's Supplemental Position Summary Dated August 10, 2005: " This letter is filed as a supplemental response to the Request for Medical Dispute resolution requested by Harris Methodist H.E.B. and **Cross-Requestor's request for order of refund.** Carrier has previously responded to this dispute on 07/13/2005. Carrier maintains its position as outlined in the original response. **Requestor has not responded to Cross-Requestor's request for an order of refund …"**

Response Submitted by: Flahive, Ogden & Latson

Respondent's Supplemental Position Summary Dated September 08, 2011: "Based upon Respondent's initial and all supplemental responses, and in accordance with the Division's obligation to adjudicate the payment, in accordance with the Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
February 24, 2005 through February 27, 2005	Inpatient Hospital Services	$28,924.01	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 1 (Z695) – The charge for this hospitalization have been reduced based on the fee schedule
- 2 (Z505) – The charge for this procedure exceeds fair and reasonable
- 3 (Z560) – The charge for this procedure exceeds the fee schedule or usual and customary allowance
- 1 (U301) – This item was previously submitted and reviewed with notification of decision issued to payor/provider (duplicate invoice)

Issues

1. Did the audited charges exceed $40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?
5. Is the respondent entitled to an order or reimbursement or refund?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the

requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $87,656.84. The division concludes that the total audited charges exceed $40,000.

2. The requestor in its position statement does not mention unusually extensive. As noted above, the Third Court of Appeals in its November 13, 2008 rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services." The requestor failed to discuss or demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).

3. In regards to whether the services were unusually costly, the requestor in its position statement does not address unusually costly. The third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must ***demonstrate*** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to discuss or demonstrate that the particulars of the admission in dispute constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).

4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was three days. The surgical per diem rate of $1,118.00 multiplied by the length of stay of three days results in an allowable amount of $3,354.00.
   - Review of the medical documentation provided finds that although the requestor billed items under revenue code 278, no invoices were found to support the cost of the implantables billed. For that reason, no additional reimbursement is recommended

   The division concludes that the total allowable for this admission is $3,354.00. The respondent issued payment in the amount of $36,807.63. Based upon the documentation submitted, no additional reimbursement can be recommended.

5. In its response to the request for medical fee dispute resolution, the insurance carrier and respondent in this dispute requested "This letter is filed as a supplemental response to the Request for Medical Dispute resolution requested by Harris Methodist H.E.B. and **Cross-Requestor's request for order of refund**. Carrier has previously responded to this dispute on 07/13/2005. Carrier maintains its position as outlined in the original response. **Requestor has not responded to Cross-Requestor's request for an order of refund** …" Former 28 Texas Administrative Code §133.304(p), 17 Texas Register 1105, effective February 20, 1992, provided, in pertinent part, that "An insurance carrier may request medical dispute resolution in accordance

with §133.305 if… the insurance carrier has requested a refund under this section, and the health care provider: (1) failed to make payment by the 60th day after the date the insurance carrier sent the request for refund…" Former 28 Texas Administrative Code §133.305(a)(2)(C), 27 Texas Register 12282, effective January 1, 2003, provided that "a carrier dispute of a health care provider reduction or denial of the carrier request for refund of payment for health care previously paid by the carrier (refund request dispute)" can be a medical fee dispute. Former 28 Texas Administrative Code §133.307(b)(3), 27 Texas Register 12282, effective January 1, 2003, specified that "The carrier... in a dispute involving a carrier's refund request" may be a requestor in a medical fee dispute. Section 133.307(e) required that "…carrier requests for medical dispute resolution shall be made in the form, format, and manner prescribed by the commission." Section 133.307(e)(2)(B) required that the request shall include "a copy of each… response to the refund request relevant to the fee dispute..." The division finds that the insurance carrier's position statement in response to the health care provider's request for medical fee dispute resolution does not constitute a request for refund request dispute resolution in the form and manner required by former applicable version of 28 Texas Administrative Code §133.307. Furthermore, no documentation was found to support that the insurance carrier ever presented a refund request to the health care provider to support its burden of proof for a specific refund amount in accordance with §133.304(p). The division concludes that the insurance carrier has not met the requirements of §133.304(p) or §133.307(e). For these reasons, the respondent's request for an order of reimbursement is not proper, and is not supported. An order of reimbursement for the respondent is therefore not recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to discuss and demonstrate that the disputed inpatient hospital admission involved unusually extensive, and unusually costly services. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/9/12
Signature	Medical Fee Dispute Resolution Officer	Date
		11/9/12
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.